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Congenital Rubella Birth in Seattle

On October 18, a resident practicing at a tertiary referral center in Seattle notified Public Health about an infant born on September 30 and transferred on October 5 from the birth hospital. The infant was small for gestational age and had meconium aspiration, petechiae, ventricular septal defect, thrombocytopenia, patent ductus arteriosis, intracranial calcifications, splenomegaly, and microcephaly. Congenital rubella syndrome (CRS) was confirmed when sera and clinical specimens (throat swab, urine, and stool) submitted to the Washington State Public Health Lab were reported positive for rubella-specific IgM antibody and viral culture (from the throat swab), respectively.

The infant's mother had experienced a rash illness the last week of January at approximately 5 weeks gestation. She had been diagnosed in her home country of Honduras early in February with "rubeola" by positive rubella-specific IgM antibody, and had been instructed to have an ultrasound. When she presented to her Seattle health care provider at 20 weeks' gestation, she told her provider that she had had "rubeola" ("rubeola" is the Spanish word for the disease rubella, whereas the Spanish word for measles is "sarampion") early in the pregnancy and required an ultrasound. When her prenatal testing showed her to be immune to rubella by presence of IgG, and the pregnancy was unremarkable, no ultrasound was performed.

Infants with CRS often shed rubella virus for a year or more after birth, making them a potential source of transmission to nursery personnel and other contacts not immune to rubella. Once this child's CRS diagnosis had been confirmed, the immune status of all exposed staff from both hospitals was evaluated. At the birth hospital, 85 nursery, labor & delivery, and peri-partum staff, including 7 family practice residents & attendings, and 48 infants had been potentially exposed. All staff had documented immunity on file. Maternal immune status was unknown for only one infant, whose mother was subsequently found to be immune. At the tertiary care hospital, 261 staff and 20 infants had been potentially exposed; five infants had shared a room with the case, and 15 more were on the same unit. There was no documentation of maternal rubella serology on three infants, and the pediatricians of these three infants were notified. Documentation of immunity was available for 230 (88%) of the potentially exposed staff. Of 23 staff who were serologically tested, 21 were found to be immune.

One staff member (a housekeeper) was equivocal for rubella antibody, and received MMR immunization. Another staff member in direct contact with the infant (a translator) was negative for rubella antibody, received MMR immunization and was placed on furlough for the duration of the incubation period. Immune status remains unknown for 8 staff (3%), all of whom are physicians.

Rubella, as this case illustrates, is a potentially disastrous disease when acquired by a mother early in pregnancy. It can lead to premature delivery, congenital defects, and fetal death, depending on gestational age at time of infection. Up to 85% of infants infected in the first trimester of pregnancy are affected. An average of 5 CRS cases have been reported annually in the U.S. since 1980. Most reported post-natal rubella in the U.S. since the mid-1990's has occurred among Hispanic young adults who were born in Latin America and the Caribbean where rubella vaccine is not routinely used. CRS prevention is the primary objective of rubella vaccination and surveillance programs in the U.S.

Additionally, since 346 staff with potential for exposure were identified, this case highlights the importance of having an employee policy in place , including physicians on staff, regarding communicable diseases, including measles, rubella and varicella, so that documentation of immunity is readily available when exposures to personnel occur.

Adult Tetanus/Diphtheria Vaccine (Td) Update

Manufacturing problems at Wyeth-Lederle and Aventis Pasteur laboratories have resulted in a shortage of adult tetanus/diphtheria toxoid (Td) in the United States. Wyeth-Lederle is unsure when they will resume releasing Td and Aventis Pasteur is limiting the number of doses shipped to providers to no more than 25 doses/shipment/week in order to extend the available supply as along as possible.

For Washington State providers receiving state-supplied Td for children under 19 years of age, Public Health is able to ship Td in limited quantities. State-supplied Td vaccine can no longer be used for adults age 19 and over.

Until the supply of Td improves, ***providers should delay routine administration of Td.*** **Persons whose doses are delayed should be recalled and vaccinated when the supply increases. Available Td should be used for management of high-risk wounds.** If Td vaccine is not available, providers should utilize single antigen tetanus toxoid for wound management. Providers may contact Aventis Pasteur to place orders for Td vaccine directly by calling 1-800-822-2463, or through their website at http://www.vaccineshoppe.com.

Influenza Vaccine Update

According to vaccine manufacturers and the Centers for Disease Control and Prevention (CDC), health care providers should receive all ordered influenza vaccine by the end of December. **Health care providers are asked to prioritize their use of currently available influenza vaccine supplies to ensure that people at highest risk for influenza-related complications are vaccinated first.** At highest priority for vaccination are people at high risk of complications if they get influenza disease, their family members, and health care workers. Specifically, this includes:

- everyone age 65 years and older;
- anyone age six months and older who has asthma, chronic heart or lung disease, diabetes mellitus, kidney disease or immune suppression (including HIV);
- children on long-term aspirin therapy;
- pregnant women who will be at least 14 weeks pregnant during influenza season;
- health care workers, and
- family members of people at risk of influenza complications.

Otherwise healthy people who are not in high-risk groups should be immunized in late November or December. Because the peak of the influenza season usually occurs in January or later, and can last through March, immunization efforts should continue into January and February.

CDC has contracted with Aventis Pasteur for an additional 9 million doses of influenza vaccine (see below*). This additional production ensures that approximately the same quantity of influenza vaccine will be available for the 2000-01 season as the previous year. These 9 million doses are not intended to substitute for vaccine that is already ordered and expected to be delivered.

Thus far this year, no confirmed cases of influenza have been reported in King County; one confirmed case of influenza (type B) has been identified in the state. CDC reports that during October, sporadic cases of Influenza A (H1N1) were identified in California, Florida, and Texas and H3N2 viruses were identified in California, Hawaii, and Kentucky.

During August--October, influenza B viruses were identified in Alaska, California, Nevada, Oklahoma, and Washington. Nationally, this level of activity is typical for this time of year. Most viruses isolated since April worldwide are well matched to strains in the current vaccine.

Additional information about influenza vaccine availability is also available from the American Lung Association's Flu Hotline (206-441-5100, ext. 83) and the CDC website at: http://www.cdc.gov/nip/flu-vac-supply. Updated CDC influenza surveillance data are available at: http://www.cdc.gov/ncidod/diseases/flu/weekly.htm. Local influenza information including current influenza vaccine clinics and surveillance updates for King County are available on the Public Health website: http://www.metrokc.gov/health.

Public Health is administering influenza vaccine to high-risk individuals in November. Vaccine should be available for the general population in December. If you have influenza vaccine that you can loan to others for use in high-risk populations, please contact Betsy.Hubbard@metrokc.gov.

***Important note on ordering influenza vaccine from Aventis Pasteur:** To obtain CDC-contracted influenza vaccine, fill out an application/order form available at: http://www.vaccineshoppe.com or by calling 1-800-720-8972. Additional information is available at 503-772-0670.

Disease Reporting (area code 206)
AIDS……296-4645
Communicable Disease…296-4774
STDs……..731-3954
Tuberculosis……731-4579
24-hr Report Line……296-4782

Hotlines:
CD Hotline……296-4949
HIV/STD Hotline……..205-STDS

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http://www.metrokc.gov/health

Reported Cases of Selected Diseases Seattle-King County 2000

NR= Not reportable in 1999	Cases Reported In October		Cases Reported Through October	
	2000	1999	2000	1999
AIDS	15	19	208	183
Campylobacteriosis	31	17	281	235
Cryptosporidiosis	1	NR	5	NR
Chlamydial infections	321	332	3744	3180
Enterohemorrhaghic *E. coli* (non-O157)	0	NR	1	NR
***E. coli* O157: H7**	5	6	56	39
Giardiasis	20	15	196	165
Gonorrhea	103	102	928	785
***Haemophilus influenzae B* (cases <6 years of age)**	0	0	0	0
Hepatitis A	4	24	87	173
Hepatitis B	6	2	38	34
Hepatitis C/ non-A, non-B	1	2	10	8
Herpes, genital	43	55	637	555
Measles	0	0	2	1
Meningococcal Disease	1	2	12	20
Mumps	0	0	9	1
Pertussis	25	13	183	436
Rubella, congenital	1	0	1	0
Rubella	0	0	1	2
Salmonellosis	9	13	184	240
Shigellosis	7	7	140	51
Syphilis, congenital	0	0	1	0
Syphilis, late	0	9	23	40
Syphilis	6	5	62	66
Tuberculosis	14	11	103	93